TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Orthopedic Hospital

Respondent Name
Sentinel Insurance Company Ltd

MFDR Tracking Number
M4-17-2955-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the hospital would have been entitled to $8,596.06 in reimbursement. The Carrier only paid $4,802.43. Therefore, the Hospital contends an additional $3,793.63 remains owed."

Amount in Dispute: $3,793.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts this claim was properly reimbursed in accordance with TAC §134.403 and that no additional is due. The bill did not hit outlier and therefore it was appropriately reimbursed at the wage adjusted OPPS rate for CPT 29881 and 97001 per the Texas fee schedule."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 17, 2016	Outpatient Hospital Services	$3,793.63	$1,421.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- 28 Texas Administrative Code §133.240 sets out the guidelines for medical payments and denials.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes:

- 97 – Payment adjusted because the benefit for the service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the fee applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $3,793.63 for outpatient hospital services provided on August 17, 2016. The insurance carrier denied disputed services with claim adjustment reason code 97 – "Payment adjusted because the benefit for the service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   28 Texas Administrative Code §134.403 (b) (3) and (d) applies to outpatient hospital services and states in pertinent parts,

   > (b) (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
   >
   > (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided

   How the Medicare payment calculations for outpatient hospital claims is found at the link below. The Medicare Claims processing Manual defines the terms, and Status Indicators as follows:

   > **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
   > - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

   – **10.1.1 - Payment Status Indicators**

   An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

   The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

   – **10.2 - APC Payment Groups**
   Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount

calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

Review of the submitted medical claim finds the services designated with a HCPCS code have status indicators as follows:

- Procedure code J1885 has status indicator N, denoting packaged codes integral to the total service package with no separate payments.
- Procedure code J2250 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
- Procedure code J2270 has status indicator N.
- Procedure code J2704 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
- Per Medicare policy, procedure code 29875 may not be reported with procedure code 29881 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure. Separate payment is not recommended.
- Procedure code G8978 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Procedure code G8979 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Procedure code G8980 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Procedure code J0690 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
- Procedure code J1100 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2405 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.
- Procedure code J3010 has status indicator N, denoting packaged codes integral to the total service package with no separate payment.

Based on the above the carrier's denial of 97 – "Payment adjusted because the benefit for the service is included in the payment/allowance for another service/procedure that has already been adjudicated" is supported for the services listed above. The fee guidelines for the remaining services in dispute are found below.

2. The maximum allowable reimbursement is calculated per the provisions of 28 Texas Administrative Code 134.403 (f) which states in pertinent part,

   The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent;

The Medicare facility specific amount is calculated below:

- Procedure code 29881 has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 100%. This is assigned APC 5122. The OPPS Addendum A rate is $2,395.59. This is multiplied by 60% for an unadjusted labor-related amount of $1,437.35, which is multiplied by the facility wage index of 0.9615 for an adjusted labor amount of $1,382.01. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is $2,340.25. The Medicare facility specific amount of $2,340.25 is multiplied by 200% for a MAR of $4,680.50.
- The respondent states in their position statement, "A desk audit was performed and upon review it was determined that code 29999 was best represented by 29877, which is a bundled procedure code and therefore not separately reimbursable." 28 Texas Administrative Code §133.240 (c) states,

  > The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.

  Therefore, the carrier's denial and position statement of Code 29999 is not supported. The code in dispute will be reviewed to establish the Medicare facility specific amount.

  Procedure code 29999 has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 50%. This is assigned APC 5121. The OPPS Addendum A rate is $1,455.26. This is multiplied by 60% for an unadjusted labor-related amount of $873.16, which is multiplied by the facility wage index of 0.9615 for an adjusted labor amount of $839.54. The non-labor related portion is 40% of the APC rate, or $582.10. The sum of the labor and non-labor portions is $1,421.64. The total Medicare facility specific amount, including multiple-procedure reduction, of $710.82 is multiplied by 200% for a MAR of $1,421.64.
- Procedure code 97001 has status indicator A, denoting services paid by fee schedule or different payment system from OPPS. If Medicare pays using other systems, Rule §134.403(h) requires use of the DWC fee guideline applicable to the item on the date provided. Professional services are paid using the DWC Professional Medical Fee Guideline, Rule §134.203(c). The Medicare rate for this code for 2016 is $76.83. This amount divided by the Medicare conversion factor of 35.8043 and multiplied by the DWC conversion factor of 56.82 yields a MAR of $121.93.

The total recommended reimbursement for the disputed services is $6,224.07. The insurance carrier has paid $4,802.43 leaving an amount due to the requestor of $1,421.64. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,421.64.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $1,421.64 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this order.

Authorized Signature

	Peggy Miller	June 29, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.